Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Rehabilitation Agencies and PTs, OTs, STs

Subject: Prior Authorization Changes, Medicare Part B Reimbursement Limitation, and Clarification

Date: June 15, 1988

Code: MAPB-088-017-D

The purpose of this bulletin is to (1) communicate new policies concerning prior authorization thresholds and reimbursement of Medicare coinsurance; (2) clarify or reiterate policies which were communicated in previous bulletins; and (3) correct errors which were printed in previous bulletins.

This bulletin should be used in conjunction with the Medical Assistance Provider Bulletin MAPB-087-037-X and the individual therapist bulletins MAPB-087-013-D through MAPB-087-016-D, all dated September 1, 1987.

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This bulletin includes important information on the following:

Wisconsin Department of Health and Social Services, Division of Health, Bureau of Health Care Financing, Provider/Recipient Services, P.O. Box 309, Madison, Wisconsin 53701

I. REDUCTION IN PRIOR AUTHORIZATION THRESHOLD FOR THERAPY SERVICES

In the 1989 Budget Bill, the legislature enacted a reduction in the prior authorization threshold for therapy services from the current 45 treatment days per spell of illness to 35 treatment days per spell of illness. The Wisconsin Administrative Code is being amended by Emergency and Permanent Rule to reflect these changes. Therefore, effective for new spells of illness beginning on or after July 1, 1988, occupational therapy, physical therapy, and speech pathology services provided by a rehabilitation agency or independent therapist will require prior authorization for all services in excess of 35 treatment days per spell of illness. Evaluations are included as treatment days for the purpose of determining when prior authorization is required. As a reminder, therapy services provided to recipients who are hospital inpatients are exempt from these prior authorization requirements. Therapy services provided through a home health agency are subject to the PA requirements outlined in the Home Health Agency Provider Bulletins. Providers are also reminded that when a hospital is the billing provider and therapy services are being provided on an outpatient basis, prior authorization requirements are temporarily discontinued while prior authorization procedures are being developed for hospital providers.

Spells of illness for which the first day of treatment or evaluation has occurred prior to July 1, 1988, will remain subject to the 45 treatment day prior authorization requirement. Therefore, treatment days already received by recipients under a spell of illness (either initial spell of illness or a spell of illness approved by the WMAP) which began before July 1, 1988, will count towards the 45 treatment day prior authorization threshold. Spells of illness for which the first day of treatment or evaluation occurs on or after July 1, 1988, will count toward the 35 treatment day prior authorization threshold for therapy services.

Recipients who are receiving therapy services under a prior authorization in progress prior to July 1, 1988, are unaffected by the change in the new prior authorization threshold.

II. LIMITATION ON WISCONSIN MEDICAL ASSISTANCE PROGRAM PAYMENTS FOR MEDICARE PART B COINSURANCE

A provision of the 1987-1989 state budget Act 27, Chap. 20, for the Wisconsin Medical Assistance Program (WMAP) establishes a limitation on WMAP reimbursement for Medicare Part B coinsurance. This limitation is authorized by Section 49.46(2)(c), Wis. Stats. Effective for dates of service on or after July 1, 1988, WMAP payment for Medicare Part B coinsurance is limited to the WMAP maximum allowable fee less the Medicare payment for the service.

This requirement applies to all services (e.g., physician, therapy, durable medical equipment, transportation) where Medicare coinsurance is billed to the WMAP for recipients who are eligible for both Medicare Part B and Medical Assistance (dual entitlees). This change in reimbursement will occur automatically. All billing for coinsurance, as well as WMAP reimbursement for Medicare Part B deductible, will be unchanged from current procedures.

For Medicare Part B coinsurance, WMAP will pay the lower of the following:

1. WMAP maximum allowable fee/rate less the Medicare payment, or

2. The Medicare coinsurance billed to the WMAP.

Any applicable copayment for WMAP services will be deducted from the WMAP payment to the provider.

The following examples illustrate how this limitation will work:

		Example I	Example II	Example III
A.	Provider's charge for a service	$120	$120	$120
B.	Medicare Part B reasonable charge	100	100	100
C.	WMAP maximum allowable fee for the service	90	110	75
D.	Medicare payment (80% of reasonable charge	80	80	80
E.	Maximum amount allowed for payment of coinsurance (i.e., WMAP fee less Medicare payment: C - D)	10	30	-0-
F.	Medicare coinsurance billed to MA (20% of reasonable charge)	20	20	20
G.	WMAP payment for coinsurance (lesser of E or F)	10	20	-0-

As a reminder, providers must accept assignment when billing both Medicare and the WMAP. In accordance with federal and state law and provider "Terms of Reimbursement," providers must accept WMAP payment for coinsurance as payment in full and may not charge recipients for any amount greater than WMAP's payment considered "unpaid" by the provider.

III. CLARIFICATION OF BILLING AND PRIOR AUTHORIZATION INSTRUCTIONS

The following clarifies information included in previous therapy bulletins. Therapy providers should read this information carefully and make noted changes to billing and prior authorization instructions in the appropriate September 1, 1987, bulletins:

MAPB-087-013-D	-	Occupational Therapists
MAPB-087-014-D	-	Physical Therapists
MAPB-087-015-D/002-HA	-	Speech Therapists

A. Claim Sort Indicator

The therapy bulletins issued on September 1, 1987, instructed therapists dispensing durable medical equipment (DME) items to use claim sort indicator "T" when billing for these items. This procedure has caused some problems when processing these types of claims.

To avoid these problems, the claim sort indicator is being changed. Effective with claims recieved at E.D.S. Federal Corporation (EDS) on or after July 1, 1988, therapists billing for DME services must submit a separate claim form for DME claims indicating a "D" as the claim sort indicator. Therapists should continue to use claim sort indicator "T" when billing for therapy services.

B. New Prior Authorization Instructions

Effective with the prior authorization requests received at EDS on or after July 1, 1988, occupational, physical, and speech therapy providers must:

1. Indicate the appropriate type of service code in Element 17 of the Prior Authorization Request Form (PA/RF) when requesting a therapy spell of illness:

   1 - Therapy provided by Independent Therapists
   9 - Therapy provided by Rehabilitation Agencies

2. Indicate the total number of treatment days/sessions requested in Element 19 of the PA/RF form.

C. Correction of Attachment 4 in MAPB-087-014-D (Physical Therapy Providers)

Attachment 4 of MAPB-087-014-D, dated September 1, 1987, indicated procedure code 05724 converted to HCPCS procedure code A4572 for a rib belt. The correct HCPCS procedure code should be L0210. Attachment 4 in the above referenced September bulletin should be corrected to reflect this change.

D. Correction of Attachment 4 in MAPB-087-013-D (Occupational Therapy Providers)

Attachment 4 in MAPB-087-013-D, dated September 1, 1987, indicated procedure code 08871 converted to HCPCS procedure code W6831 for a lapboard/lap tray. This item should be corrected to reflect that it is not a covered service for nursing home residents.